FD-CSFP-01
5/03

Kentucky Department of Agriculture
COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION/CERTIFICATION

County #: _____ Local Agency ID:_____ Certification Site ID: _____

Applicant Information

Applicant Name:		Date of Birth:	Sex: ☐ M ☐ F	Application Date:
Street Address:	City:	State: **Kentucky**	Zip code:	Phone Number:
Authorized Representative #1:	AR Phone Number:	Authorized Representative #2:		AR Phone Number:

Racial/Ethnic Data (For Statistical Purpose Only)

☐ American Indian/ Alaskan Native	☐ Asian/ Pacific Islander	☐ Black (Not of Hispanic Origin)	☐ Hispanic	☐ White (Not of Hispanic Origin)	☐ Other _____

This certification form is being made in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes. I have been advised of my rights and obligations under the Program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

I undersigned, certify that I have not applied for or received benefits from any other Commodity Supplemental Food Program (CSFP) in the month of application; nor will I apply for and receive CSFP or WIC benefits in subsequent months at the same time as I received in the benefits this application, if I am certified.

Signature of Applicant: _____ Date: _____

The Kentucky Department of Agriculture Division of Food Distribution operates CSFP in accordance with the United States Department of Agriculture policy, which prohibits discrimination on the basis of race, color, national origin, sex, religion, age, disability, political beliefs, sexual orientation or marital or family status, (Not all prohibited bases apply to all programs)

Certification Data (To be completed by Program staff)

Action: Date: ☐ Initial _____ ☐ Re-certification _____ ☐ Change _____	Initial Certification Completion Date: _____	Re-certification Completion Date: _____
Priority: (Check appropriate box) ☐ 1. Infant (0-3mos.) ☐ 2. Infant (4-12)mos. ☐ 3. Pregnant / Breastfeeding ☐ 4. Child (1-6 yrs old) ☐ 5. Postpartum / Non-Breastfeeding ☐ 6. Elderly (Age 60 & up) ☐ 7. Elderly (Age 60 / Homebound)	Household Income: _____ ☐ Weekly ☐ Monthly ☐ Yearly Number of people in HH: _____	Status: ☐ Eligible (Participating) ☐ Eligible (Placed on Waiting List) ☐ Moved From Waiting List Date:_____ ☐ Not Eligible ☐ Closed/Terminated Reason not eligible or terminated: _____ Date Notice Sent: _____
Documentation of Verification Method: ☐ Categorical eligibility: _____ ☐ Income eligibility: _____ ☐ Residence: _____		

I hereby certify that this assessment was made on the basis of information contained within agency files. All eligibility criteria were applied as defined by the Kentucky Department of Agriculture Division of Food Distribution.

Signature of Agency Official: _____ Title:_____

Referrals

Indicate any referrals made to other service below:	Documentation:
☐ WIC program Date: _____ ☐ Food Stamp Program Date: _____ ☐ Supplemental Security (SSI) Date: _____ ☐ Other: _____ Date: _____	

White Copy - Local Agency Pink Copy - Certification/Distributing Site